**DORSET SAFEGUARDING CHILDREN BOARD**
**SYNOPSIS OF LEARNING FROM A SERIOUS CASE REVIEW**

**Case 15 - Family S11**

## Introduction

In March 2014, the DSCB concluded a Serious Case Review (SCR), following the death of Andrew, a 15 year old, who had taken an overdose of available medication including medication prescribed to this father. This was the second time he had done this. Following the first time, many agencies had tried to work with Andrew and his family and at the time of his death, agencies were still trying to get him to attend The Learning Centre, but he had not done so for some months.

**This synopsis is being sent out with an 'Embedding Practice Change' form. Please use the questions contained within this synopsis to promote self- reflection and reflection and discussion within teams.**

**Please complete the form and return it to the person nominated in your agency.**

## Background

Andrew was 13 years old when he and his 11 year old sister, Annabel moved to Dorset from a city some miles away. They came with their father to be closer to father's extended family. Father had separated acrimoniously from the children's mother and they had chosen to live with him. Within a short time, non school attendance problems, which had previously been chronic, re-occurred in Dorset. Within months, the school nurse made a referral to Children's Services Social Care because of non school attendance, non take up of immunisations and concerns about father's mental health and alcohol use. Father was also reporting that Annabel had an emerging mental health problem.
When the Social Worker visited to complete an assessment they had to call the emergency services as Andrew and his girlfriend had taken an overdose of father's medication and were impossible to rouse. Andrew spent the night in hospital and went back to his father's care after a CAMHS assessment.

Following this there were 18 months of significant input from a Locality Social Worker, Child Care Social Worker, CAMHS worker, Education; both school and learning centre, Housing (the family were re-housed into Social Housing) and the GP. During this period, practitioners tried to engage the family meaningfully time and time again. There were Team around the Child meetings, Child in Need meetings, a Core Assessment and School meetings; however no agency managed to engage the family effectively for any significant time. Andrew's mental and physical health reportedly fluctuated during this time and he was diagnosed with depression and given anti-depressants. Significantly, during this period Annabel returned to her mother's care where she flourished. Andrew got into a fight and was seen at casualty under the suspected influence of drugs. After 18 months, the Child Care Social Worker and CAMHS closed their cases; the responsibility being with the Locality Social Worker and the Learning Centre staff to continue to address the non school attendance issues, as this was seen as the primary area of need. For 4 months, these services continued to try to engage Andrew, but did not get entry to his home.

Andrew was found dead one morning by his father. He had taken an overdose of medication, that it is believed his father brought into the home. At the time of death, Andrew's physical presentation was poor. He and his father were living in the combined kitchen/living area of the home with Andrew's bedroom unusable. No-one knows Andrew's motivation for taking that final fatal overdose. The Serious Case Overview Author concluded that his death was not predictable, however there were learning points for all agencies.

**Learning**

- ***The challenge of working with 'hard to reach' families:***
  This was a family that did not engage consistently and many imaginative efforts were used to try and effect engagement. However, ultimately significant agencies closed the case at the same time.
  Overall however, there was little attempt to really understand why the family were not engaging. Being clearer about their motivation may have prompted work that addressed these issues more effectively. In future, agencies should give consideration to holding a professionals meeting when families will not engage, with the purpose of trying to understand and plan how to address the reasons for non engagement. It is not a question of doing more, harder; it is a question of doing things differently. If the decision is to close the case, the full implications, including risks should be understood by all agencies prior to closure.

- ***Teenage Neglect and the relevance of the Child Protection Procedures:***
  Andrew looked older than 13 years and this may have contributed to why the Child Protection Procedures were never implemented, despite numerous "threats" to do so. Assessments were completed but they lacked detail and didn't identify risk and events were often seen in isolation. At times, workers concentrated on Annabel and seemed desensitised to Andrew's vulnerability. Child Protection Procedures are relevant to teenagers and the impact of neglect is just as harmful as that on younger children. Tools, such as the Graded Care Profile and chronologies, would support an objective assessment of risk for every child. There are challenging dilemmas for practitioners who balance the adolescent's wishes and feelings with a real understanding of their competence and ability to manage risk for themselves. This is an area in which practitioners have to be supported to do better.

- ***Youth mental health and suicidal ideation:***
  There was not enough weight given to Andrew's early history and the environment in which he was living. The relevance of the first overdose was not fully considered in respect of his emotional and mental health. The implications for future risk were not understood and addressed in planning intervention. Self harming and suicidal ideation must be seen as an indicator that a child is at risk of harm and should prompt consideration of the Child Protection Procedures. Although information was shared in this case, at no point was it brought together effectively with curious questions being asked to really understand what it was like for Andrew living in his situation, dealing with his father's mental health problems and his feelings of maternal rejection.

- ***Adult mental health and implications for learning:***
  Father's mental health diagnosis was believed to be part of the reason for non engagement. However, attempts to find and work out the implications for parenting capacity fell short. It is recognised there is a gap in current procedures, training and guidance and that a tool must be developed to assist practitioners across all agencies and work will be done to facilitate this. In addition, practitioners across agencies must work together to embed this.

- ***Regular reflective and purposeful supervision:***
  Again, this review showed that the best way to support practitioners to deal with the complex cases they work with on a daily basis is effective supervision. In this case, workers should have been challenged to think through issues in respect of Teenage Neglect and thresholds for child protection. They should have been challenged to consider why the family were not engaging and find ways to address this. The impact of closing the case should have been considered within the context of dealing with a young person, who is expressing wishes and feelings that were counter to what was in his best interests. This is a dilemma that practitioners face every day and it is imperative that managers should have the skills to enable practitioners to effectively work these complex cases. Supervision should be regular and effective.

**In Conclusion**
This Synopsis of Learning should be read in conjunction with that for Case 16 – Domestic Homicide Review C3. There are a number of overlapping messages about non engagement and Teenage Neglect and these have been amalgamated for action. We really need to work together in Dorset to address these issues. There are a number of conferences addressing Teenage Neglect and these are a valuable opportunity to improve awareness and learning. Remember – teenagers are entitled to the same consideration as younger children and although working with them can often be more complex, the outcomes for teenagers when we fail them can be significant. We hope that this Synopsis encourages practitioners to share and talk about the dilemmas they face and to improve understanding and practice.

***Addendum - Process of conducting this Review***
*For this Serious Case Review, a systemic Partnership Learning Model was used. Following 'Working Together to Safeguard Children 2013', LSCB's are required to take Serious Case Reviews forward using a systemic model; there have been too many Serious Case Reviews in the past with many recommendations that have not impacted on frontline practice.*
*This systemic model should change that as practitioners are actively involved in the learning helping the Overview Author and the Senior Managers in organisations better understand why they took the actions that they did. With this understanding comes the basis for real change to frontline practice.*

*Practitioners come to work to support and intervene with families to the best of their ability and only by considering what worked well and what went wrong in a systemic way, can future recommendations really bring about change that makes a difference to children and families.*
*For practitioners, being involved in the learning event can be both challenging and enlightening, however, many practitioners have valued the opportunity to contribute to this Review.*

*In future, more Reviews in Dorset will be undertaken in a systemic way and this Review is seen as a beginning. The entire Review has been published on the DSCB website; for clarity, the same anonymised names used in this Synopsis as are used by the Overview Author in the Review.*

## Questions to consider within your team:

***Issue: Working with 'hard to reach' families***

**Think:**

- **Do the messages here have relevance for my practice?**
- **Am I currently working with any families who may benefit from a multi-agency 'Hard to Reach'* meeting?**
  **A multi agency 'Hard to Reach' meeting is a recommendation that came out of this SCR. It was recognised that practitioners needed the opportunity to step back and really consider <u>why</u> the family or young person would not engage and address the underlying issue.*
- **Are there cases I am working with where the threshold for the inter-agency Safeguarding Children procedures may apply?**
- **(For agencies other than social care) - Am I confident to challenge social care practitioners regarding their response to adolescent neglect?**
- **(If you are a manager) - Do I need to make any changes in my supervision practice?**

***Issue: Teenage Neglect and the relevance of the Child Protection Procedures***

**Think:**

- **Are there cases I am working with where the threshold for the inter-agency Safeguarding Children procedures may apply?**
- **(For agencies other than social care) - Am I confident to challenge social care practitioners regarding their response to adolescent neglect?**
- **(If you are a manager) - Do I need to make any changes in my supervision practice?**

***Issue: Regular reflective and purposeful supervision***

**Think:**

- **(If you are a manager) - Do I need to make any changes in my supervision practice?**

**Please consider these questions in your team and complete the attached Embedding Practice Change form returning this to your agency safeguarding lead.**

**Safeguarding children is everybody's business.**

**For information on what to do if you are worried about a child or if you want information about safeguarding or policies and procedures please go to www.dorsetlscb.co.uk**

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